Vaccine Equity Cooperative

Advancing Children's Health: Promoting COVID-19 Vaccination and Mitigation Measures

Recommendations to Protect Children Under Age 12 and Their Families and Communities

WORKING DOCUMENT CREATED BY CHILDREN'S COVID-19 VACCINE EQUITY STRATEGY WORKING GROUP

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Vaccinate Your Family

Design principles for kids' vaccine strategy and recommendations

The approach to these recommendations and for developing a children's vaccine strategy should follow some basic principles (similar to ***Global Immunization Vision and Strategy (GIVS) Guiding Principles and Strategy***) building on already existing and robust research, infrastructure, logistics, delivery and demand for childhood immunizations. Here are the design principles for the following recommendations:

- ✓ Center on racial health equity
- ✓ Prioritize outreach in the context of **whole families and communities**
- ✓ Build on existing proven infrastructure with a **"no wrong door approach"**
- ✓ Engage all sectors across **health policy, communities, schools** and **private sector**

Top Recommendations

(Italics indicate direct connection to racial health equity)

Vaccine Distribution

Most children across racial and ethnic populations, income levels, and payer types receive their routine vaccinations at one of three sites: Medical homes (pediatricians, family med or med peds clinics, FQHCs), schools and school-based clinics, or public health departments. *As a result, the community-based vaccination sites that were critical to advancing racial equity among the adult population, may not be as integral to equitably vaccinate 5-11 and 12-17 year olds.*

Critical Role for Schools and School Based Clinics

The robustness of the national school health infrastructure (school based clinics, school nurses etc.) varies by district and state. But given the core role schools play in the lives of families and communities, they are a crucial site to partner with in the vaccination effort - for disseminating information about vaccines and delivering vaccines. *Schools are also important to bridge access gaps for underserved communities who lack a medical home.*

Increased Support for Public Health Departments at All Levels

Public health departments, at the local and state level, are the backbone of targeted public health responses and in many jurisdictions the main site of vaccination for children and families who lack medical homes, are recent immigrants, or lack insurance coverage. Ensuring health departments are equipped and resourced to: support linkages between schools and medical homes, coordinate local efforts to proactively provide patients with information about vaccination, and offer vaccination, will be a necessary complement to the broader effort to vaccinate families.

Maximizing the Use of VFC

The backbone of the national effort to provide routine immunizations to the pediatric population is the Vaccines for Children program (VFC), which since its inception has helped narrow and sometimes even close gaps in routine vaccination by racial and ethnic group and across income levels. *Maximizing and optimizing use of the VFC program will be critical to equitably and effectively vaccinating 5-11 and 12-17 year olds.*

Reimburse and Incentivize Vaccine Counseling
Families will likely have questions for their pediatrician/primary care provider regarding vaccines even when they are not a vaccination site. There is no current mechanism to pay for this counseling in current billing and coding systems. *In addition, some families will require several rounds of counseling before they are ready to receive a vaccine even from their primary care provider, but the primary care provider can only receive payment when the actual administration happens. Payment systems must encourage appropriate vaccine counseling.* This is an urgent problem for CMS, state Medicaid programs, and private insurance to address. A couple of places have added reimbursement for counseling, including North Carolina Medicaid and New York City.

Enable a "No Wrong Door" Approach to Ensure Whole Families Are Vaccinated
The 5-11 roll out is an important opportunity to vaccinate families and communities and bolster community-level protection. *This is an especially important approach for communities with low vaccination rates among adult caregivers, who then may be less likely to vaccinate their children.* Family vaccination strategies capture the essence of the "no wrong door approach" and ensure caregivers and siblings are also protected when they accompany children who are 5-11 to their medical visits. But equipping vaccination sites to administer doses to clients or patients of varying ages raises important safety concerns that need to be proactively addressed.

Integrate and Equip Local Health Departments
Integrate local health departments (LHDs) and other key vaccine providers and community stakeholders into local planning to address operational challenges, effective coordination, consistent communication, and messaging, and ensure an approach to rollout with health equity at the center of the approach.

Clear, Consistent Communication Centered in Racial Health Equity
Clear, proactive, and unified communication across government agencies and all participants in the roll out for 5-11 will be critical to success. *Such coordination requires planning and information dissemination strategies that are language appropriate, culturally appropriate, scientifically accurate, simple to digest, and timely.*

Ensure Local Trusted Messengers Are Equipped With Clear Consistent Communication
Ensure that community based organizations, community health worker and promotora networks are adequately resourced and equipped with culturally appropriate and scientifically accurate information to do outreach to children, families, and communities, especially those who have experienced a disproportionate burden of COVID illness and other impacts, before and during the vaccine rollout.

Build on Bright Spots and Learnings From Local Communities
Build on learning, infrastructure, best practices and research from adult COVID vaccinations and routine childhood immunizations where public health, health care, community based organizations and community based workforce worked in concert to educate, combat misinformation and increase vaccination rates.

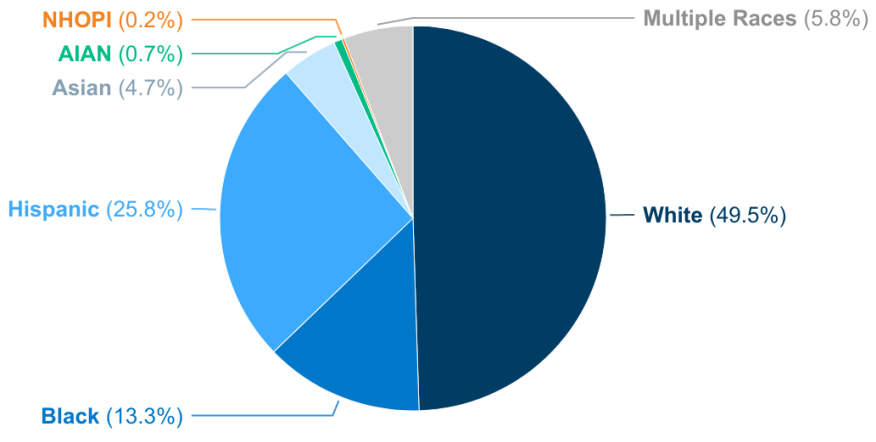
*In addition, **please see the recommendations** sent from the American Academy of Pediatrics to the White House on Oct 1, 2021.*

Top Tier Recommendations were taken from a longer list generated by multiple organizations, subject matter experts and leaders at all levels. For more detail, see below. **Top recommendations are highlighted in green**.

Overview

Since the first reported cases in January 2020, COVID-19 has infected over 45 million Americans, leading to more than 740,000 deaths. Over the course of the ongoing Delta variant surge, nearly every county in the nation experienced or is experiencing an increase in cases, hospitals and ICUs across the nation are struggling to function at or over capacity, and regionally the US South grappled with its worst outbreak since the start of the pandemic. At the same time, despite the broad availability of safe, effective vaccines, inadequately low vaccination rates and incomplete adoption of complementary public health mitigation measures have rendered groups with low vaccination rates increasingly vulnerable to COVID exposure, infection, hospitalization and death. Indeed, mitigation measures such as wearing face masks and social distancing are actively blocked in many of the same locations with the lowest vaccination rates and worst surges, creating a dangerous context for children and their families and communities. As of end of October, while approximately 54% of the U.S. population is fully vaccinated, we know only 34.4% of the nation's Black populations and 40.6% of the Hispanic/Latinx population are fully vaccinated (as of late September, 47 states and Washington D.C. were reporting vaccination data by race/ethnicity). Among the unvaccinated population, almost 48 million children under age 12 years are not yet eligible for the vaccine (almost 29 million age 5-11 years). Please see specific demographic data in figures 1 and 2.

FIGURE 1. Distribution of Children Under Age 12 by Race/Ethnicity

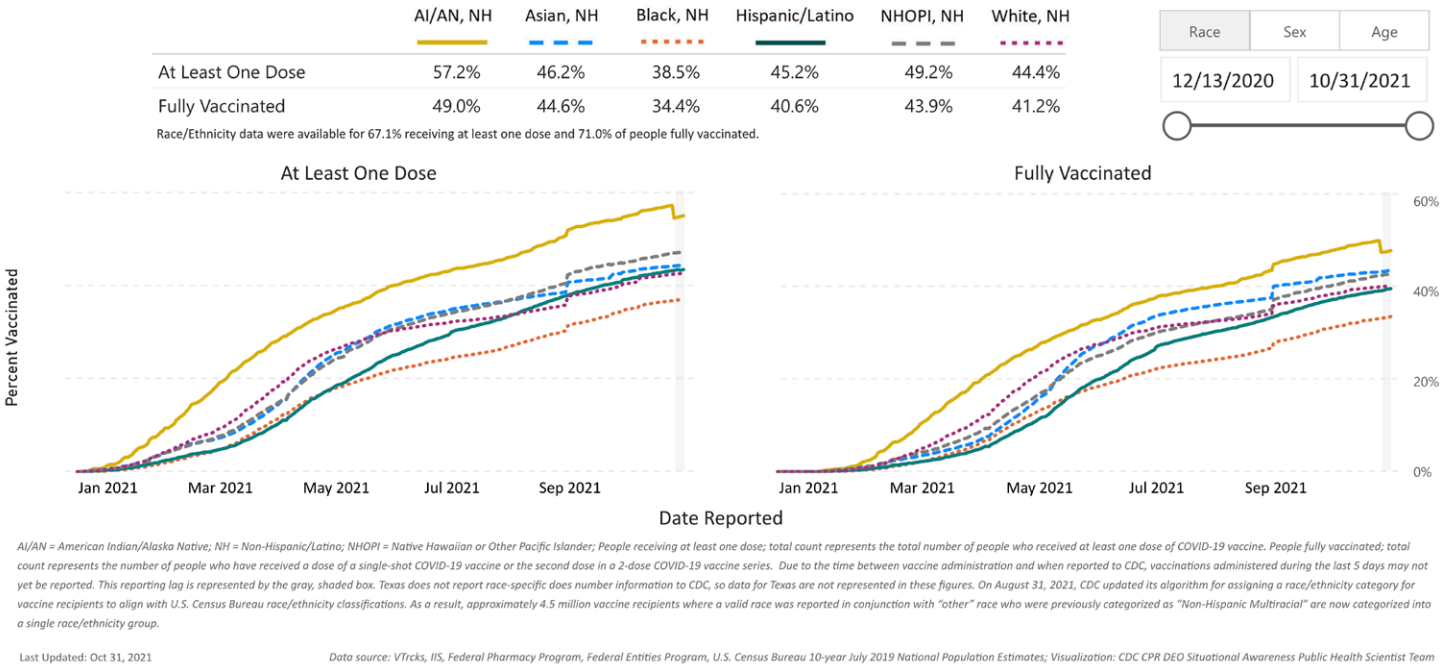


NOTE: NOTE: AIAN refers to American Indian/Alaska Native. NHOPI refers to Native Hawaiians and Other Pacific Islander. Hispanic people may be of any race but are categorized as Hispanic; other groups are all non-Hispanic.
SOURCE: KFF analysis of 2019 American Community Survey, 1-Year Estimates.

KFF

FIGURE 2. Percent of People Receiving COVID-19 Vaccine by Race/Ethnicity and Date Reported to CDC, United States

December 14, 2020-October 31, 2021



According to the American Academy of Pediatrics, approximately 206,864 cases of COVID infection were reported among children during the week of September 23, 2021, approximately, 26.7% of the total weekly case count. While COVID-19 infections in children are typically less severe than in adults, the long-term impacts of COVID-19 infection on children remain unclear and the hospitalization or death of even one child from a preventative infectious disease is one child too many. Sadly, long term consequences of childhood viral infections are common (e.g. Subacute sclerosing panencephalitis (SSPE) and shingles). It is also critical to note that as with adults, children can transmit the virus to others, contributing to community spread which can allow for variants of the virus to develop and spread. Now that the Food and Drug Administration (FDA) has issued an emergency use authorization (EUA) for a COVID-19 vaccine for children younger than age 12, some parents will likely eagerly get their children vaccinated. However, there will be challenges to vaccinate children in families or communities that lack access (to healthcare services, to information, or to vaccines themselves) or readiness. Utilizing community-based solutions including community health workers and mobile health clinics that can effectively reach groups that face barriers such as access to accurate information, social support, time, and trust will increase access. According to the Sept 30th KFF Survey, "about a third of parents (34%) say they will vaccinate their 5-11 year old child "right away" once a vaccine is authorized for their age group. About a third of parents (32%) say they will "wait and see" how the vaccine is working before having their 5-11 year old vaccinated. Notably, the share who say they definitely won't get their 5-11 year old vaccinated remains steady at one in four (24%)."

In the same KFF survey, "nearly half (48%) of parents of vaccine-eligible children ages 12-17 now say their child has received at least one dose of a COVID-19 vaccine. Another 15% of those parents now say they want to "wait and see" how the vaccine works for others before their adolescent gets it, while 4% say they would get vaccinated "only if required" for school or other activities. About one in five (21%) say their adolescent child would "definitely not" get a vaccine." Now with FDA approval, the need for trusted messengers to effectively communicate the specific benefits and safety of COVID-19 vaccination for younger children becomes even more important and more urgent.

In addition to vaccine access challenges, a number of other issues that could create additional risk to children's health and wellbeing status in the fall and winter demand our attention:

- Children have returned to school with many schools grappling with mask mandate **bans or lack of adherence**, a lack of social distancing, staff capacity gaps, insufficient testing infrastructure, and inadequate ventilation and other structural challenges.
- The combination of unvaccinated children in schools with limited or inadequate mitigation measures increases the risk that these children will experience missed schooling due to school closures or absences for illness or quarantine requirements. For children in historically marginalized communities, this educational disruption will harm the same children who faced significant challenges before the pandemic and who experienced the most intense learning loss and missed learning opportunities during the pandemic, further exacerbating educational inequities that can have lifelong impact.
- With the start of schools and businesses opening, it is likely influenza will circulate. In addition, respiratory syncytial virus (RSV), a common respiratory infection in children, is spiking **earlier** than normal this year.
- Additional COVID-19 variants are emerging that could be more infectious, and winter weather will force more activities indoors where the likelihood of transmission increases.
- As a result of COVID-19 infections, children's hospitals are already nearing **capacity** in some states as a result of the Delta variant—from **Oklahoma** to **Maryland**. A stressed health system at or over capacity could lead to challenges in meeting other acute and chronic health needs of children and families.
- As of August 2021, overall VFC provider orders (other than orders of flu vaccine) are down by 13.2 million since the start of the pandemic, and this statistic only includes vaccines for the approximately 50% of children who are eligible for the VFC program.
- Not only are millions of children behind on routine childhood vaccinations, many have not received wellness check-ups or routine care for other childhood illnesses, particularly among families that lack access to primary care. This threatens the wellbeing of our children and creates risk for emergence of other infectious diseases—along with our hard work to end the COVID-19 pandemic, **we must not neglect missed wellness check-ups and routine vaccinations**.
- 18+ months into an ongoing pandemic that has taken hundreds of thousands of lives from families across the country and interrupted social and educational patterns for our youth, we are facing a looming mental health crisis in K-12 public schools that continues to receive inadequate attention and resources.

In light of this context, we have drafted a set of recommendations aimed at ensuring a comprehensive and effective rollout of childhood COVID-19 vaccinations that centers racial health equity.

Detailed Recommendations

(Italics indicate direct connection to racial health equity)

A. VACCINE DISTRIBUTION

Most children across racial and ethnic populations, income levels, and payer types receive their routine vaccinations at one of three sites: Medical homes (pediatricians, family med or med peds clinics, FQHCs), schools and school-based clinics, or public health departments. *As a result, the community-based vaccination sites that were critical to advancing racial equity among the adult population, may not be as integral to equitably vaccinate 5-11 and 12-17 year olds. In disadvantaged, underserved and low-income communities, the focus of the vaccination efforts should be through medical homes and schools in partnership with local Community Health Centers (Federally Qualified Health Centers), public health agencies, and hospital systems.*

Medical Homes (Pediatricians, Family Practice Physicians, FQHCs, Community Health Centers, Tribal Clinics, and Other Clinical Sites)

- Decades of experience show that a pediatric medical home is the best place for children to receive vaccines, where children and their caregivers can have their questions and concerns addressed by a trusted physician. This will be particularly important with younger children as the parents and caregivers of these children will likely have more questions to discuss compared to older children.
- In addition, with the ability to co-administer COVID-19 and other vaccines, distributing COVID-19 vaccine to pediatric offices and other pediatric medical homes will greatly enhance the efforts to vaccinate children against both COVID-19 and the flu, as well as catch children up on routine vaccines they may have missed during the pandemic.

- Medical homes should be resourced to ensure primary care providers, acute care providers, and hospitalists have the funding, communications tools, vaccine supply, and reimbursement mechanisms necessary to be the backbone of the child vaccination effort. In particular, clinical sites should be the primary place that is proactively reaching out to patients to schedule appointments for immunization counseling that can be used to address parent's concerns and answer questions about the COVID vaccine within the context of each child's unique medical history. This high touch engagement is likely what will be necessary to reassure parents who have concerns and to inform parents of where they can receive the vaccines as a family. These sites should also be at the front line of efforts to administer the vaccines to pediatric patients.
    - Prepare those offices and ensure infrastructure such as storage and handling, insurance reimbursements, and reporting requirements are established prior to vaccination rollout.

- *In underserved and low-income communities, COVID vaccinations should be coordinated with wellness check-ups and routine vaccinations to limit costs associated with transportation or forgone wages.*
- *As a result of increased federal investments, FQHCs expanded their capacity to administer COVID vaccines to low income populations, and disproportionately administered COVID vaccines to Black and Latinx populations. As such, FQHCs should be considered a major resource in the effort to vaccinate pediatric populations of color.*
- *Fully funding IHS, and supporting their community-level outreach and home visiting programs can also bolster vaccination efforts in rural, tribal communities where access to other health services (i.e. pharmacies as a vaccination site) is limited.*

Schools and School-Based Clinics

The robustness of the national school health infrastructure (school based clinics, school nurses etc) varies by district and state. But given the core role schools play in the lives of families and communities, they are a crucial site to partner with in the vaccination effort—for disseminating information about vaccines and delivering vaccines. *Schools are also important to bridge access gaps for underserved communities who lack a medical home.*

- Schools are an effective and convenient place to administer vaccines to populations (i.e. adolescents) who prefer the convenience of care delivered on or near their school campus. This is particularly true for adolescents who live in jurisdictions that allow them to consent to vaccination without parental oversight.
- Schools have an unparalleled capacity to track the progress of student vaccinations and the demographic data on the students vaccinated.
    - Consider using school data as a national data resource for COVID vaccination in the pediatric population and to help elucidate the vaccination status of districts and communities—figures that are otherwise more difficult to track.

- Parents already know and trust their local schools, so a vaccine clinic or informational session at the local elementary or middle school can be influential in supporting parents considering and ultimately choosing vaccination.
  - Many mobile health clinics have relationships with and regularly visit schools for preventive and primary pediatric care.
- *Use of schools and linkages to pediatricians/medical homes is an effective best practice for caregivers who lack paid sick leave and are not able to leave work to get children immunized.*
- *This approach also fosters coordination with a health system that should monitor and treat vaccinated students who suffer potential adverse impacts.*
  - Permissions may be necessary to create these linkages where they do not already exist.
  - For children who do have a medical home, any COVID-19 vaccine administered in a school setting must be reported to that student's medical provider so they are aware the shot has been administered.

Public Health Departments and Agencies

Public health departments, at the local and state level, are the backbone of targeted public health responses and in many jurisdictions the main site of vaccination for children and families who lack medical homes, are recent immigrants, or lack insurance coverage. Ensuring health departments are equipped and resourced to: support linkages between schools and medical homes, coordinate local efforts to proactively provide patients with information about vaccination, and offer vaccination—will be a necessary complement to the broader effort to vaccinate families.

- *Public health agencies should map vaccine distribution sites to ensure locations are accessible to lower resourced communities and communities most affected by pandemic (i.e. communities of color, low income, rural) and should sustainably strengthen collaborations with CBOs, FBOs, and CHWs.*
- Local and state public health agencies should be equipped to collect data that is reported to federal agencies about childhood vaccination demographics and uptake.
- Ensure that state and local public health agencies are engaged and aware of decisions on distribution in advance so that they may do appropriate jurisdictional planning, including coordination with partners such as schools, community health centers, local hospitals and health systems, faith-based organizations, community groups, etc.
- The federal government should work with states to develop prudent public health policies with health literacy and vaccine literacy interventions to support childhood vaccination at the HP 2030 levels including the new 5 to 11 year old, and 6 months to 4 year old, COVID vaccination uptake.
  - An example could be along the lines of all 50 states that have successfully integrated childhood vaccinations into school policy as well as Massachusetts that has included seasonal flu vaccines into public policy for adults. The federal and state government and related stakeholders should support laws that require childhood vaccination when they are likely to improve the public's health, and to support more systematic qualitative and quantitative research on behavioral and social determinants of vaccination integrated with long-term, evidence-based communication programs that will build vaccine literacy in support of these laws.

- State and local public health departments are and will remain an important partner and decision-maker when it comes to vaccine allocation within states, so they should not be left out of any discussion at any level. They have valuable insight and feedback to report back to federal decision makers on what has worked, what hasn't, and what types of cover (political or otherwise) that they need in order to do their jobs. Currently, public health officials are experiencing significant and hostile criticism taking a lot of flak (and some have had their lives and the lives of their families threatened), but cannot be left out of the loop.

- Identify bright spots and share learning from communities where local officials and Boards of Health have enabled better communication and increased vaccine rates;
- 2019 National Profile of Local Health Departments: **The Profile study** represents the largest, most reliable data source on LHDs. This study describes the funding, staffing, governance, and activities of LHDs across the United States, developing a comprehensive and accurate description of LHD infrastructure and practice.

B. EXISTING CHILDHOOD AND COVID VACCINE DISTRIBUTION CHANNELS

The backbone of the national effort to provide routine immunizations to the pediatric population is the Vaccines for Children program (VFC), which since its inception has helped narrow and sometimes even close gaps in routine vaccination by racial and ethnic group and across income levels. *Maximizing and optimizing use of the VFC program will be critical to equitably and effectively vaccinating 5-11 and 12-17 year olds.*

- Create a public-facing contact/coordinator at WH and HHS who oversees the child rollout specifically. They must regularly convene relevant federal agencies in partnership with child-serving professional organizations like the American Academy of Pediatrics, to assess progress, understand gaps, and quickly respond to emerging needs.
- Increase participation of VFC providers who enroll in COVID vaccination to 100%
  - Survey VFC providers who are not enrolled to assess state level barriers to participation and address them.
- AIM members report that the single greatest challenge for VFC providers is the Pfizer vaccine packaging. We know that packaging is going to change to be more conducive to small providers, but we don't know the details or the timing. So we can't educate providers and assure them they should enroll even if they have storage and handling capacity issues.
  - A call to action could provide encouragement to enroll in the absence of detailed information about what to expect.
- For VFC providers who have signed up to administer COVID-19 vaccine in their practice but have yet to receive any doses for their patients, states and jurisdictions need to help facilitate and prioritize COVID-19 vaccination in these settings so that they can be part of the distribution and vaccination plan for children ages 5-11 as quickly as possible.

- *Given differences in state rules around vaccine distribution (which has an impact on racial equity in distribution because the racial distribution of the US population is not evenly distributed) the federal government should set guidelines for the states, and individuals should go to their state for information about distribution for ages 5-11.*
- Plans for the pediatric roll out should be shared immediately with the 64 immunization programs responsible for rollout as they are working to enroll pediatricians and other providers who reach children as COVID providers and must not be left to plan in the dark.
    - Insufficient time to plan may contribute to potential safety issues. For example, will there be a change in the Pfizer packaging (because 1190 minimum doses is not workable)? Pfizer reports that the dosage for children is 1/3 the adult dose. Will providers need to use the same vaccine as in adults, but administer the smaller dose? This could increase the risk of medical errors in drawing up the appropriate doses. Or will there be a new and different product especially for children? If there is a new product, will it require the same storage and handling and have the same expiration time frames? Allowing time to address and plan for questions like these will ensure the safest possible rollout.

The 5-11 roll out is an important opportunity to vaccinate families and communities and bolster community level protection. *This is an especially important approach for communities with low vaccination rates among adult caregivers, who then may be less likely to vaccinate their children.* Family vaccination strategies capture the essence of the "no wrong door approach" and ensure caregivers and siblings are also protected when they accompany children who are 5-11 to their medical visits. But equipping vaccination sites to administer doses to clients or patients of varying ages raises important safety concerns that need to be proactively addressed.

- Family vaccination—every site that provides vaccinations to children should also offer vaccination to siblings and caregivers of all ages.
  - Public agencies, health systems, nonprofit social service providers, CBOs, and others involved should take a whole person approach to vaccine efforts and work to include wraparound services to meet community needs and maximize each vaccine encounter.
  - To fully take advantage of this touch point with families, we must provide training to providers to receive, store, and administer dosages for multiple age cohorts: 5-11, 12-18, and adults to ensure they are equipped to distinguish and to employ the proper safety protocols.

- Employ clear labeling (i.e. color coded vials) and messaging (i.e. 5-11 receive the orange vial) regarding the age-based dosing—so parents can double check and staff can double check the correct dose for the correct age prior to giving the vaccination.

C. VACCINE ACCESS STRATEGY, DATA AND TECHNICAL ASSISTANCE

- *Integrate local health departments (LHDs) and other key vaccine providers and community stakeholders into local planning to address operational challenges, effective coordination, consistent communication, and messaging, and ensure an approach to rollout with health equity at the center of the approach.*
  - *According to NACCHO's 2019 National Profile of Local Health Departments, child immunizations are clinical services most often provided by LHDs (88%).*
  - *Additionally, local health departments serve as chief health strategists within their local communities and 98% of LHDs partner with K-12 schools. Due to these pre-existing relationships, identifying opportunities to support COVID-19 vaccination rollout among children will be incredibly important.*
  - *Finally, LHDs have utilized the use of the CDC Social Vulnerability Index data to support targeted efforts to support communities that have been most impacted by COVID and leveraging this and other data sources can support an equitable approach to vaccination rollout.*
- *Provide guidance to state and local officials early on how to use tools, such as the social vulnerability index, to prioritize deep community engagement early in the rollout and distribution in order to ensure that pediatric doses are equitably distributed*
- This work should set the stage for when vaccines are approved for 6 months to 4 years. We should be thinking about implications for this age group as this work progresses so that we are prepared.
- *CDC should obtain data about racial and ethnic distribution of vaccinations by age for national reporting by polling participating states.*
- Public health agencies should ensure vaccine administration reporting from vaccine distribution sites and regularly analyze and report disaggregated data
- There needs to be guidance for vaccinators at school-based and community vaccinations sites to properly upload COVID-19 vaccine administration data to immunization information systems (IIS).
- Include data from schools and resource schools in collection.

D. VACCINE COMMUNICATIONS STRATEGY

Parents' concerns about vaccinating their children are often specific and considered within the context of their children's or family's health history. As such, mass messaging may not be an effective tool to educate parents and promote pediatric vaccination.

Clear, proactive, and unified communication across government agencies and all participants in the roll out for 5-11 will be critical to success. *Such coordination requires planning and information dissemination strategies that are language appropriate, culturally appropriate, scientifically accurate, simple to digest, and timely.*

- Widely disseminate reliable, accurate vaccine and mask-wearing information in plain language through mass and social media

- Equip trusted sources at all levels of society including those delivering vaccinations, from pharmacies, to local MDs to community health workforces such as community health workers and promotoras

- *Public health agencies should provide resources to and work with community organizations to address parents' questions and concerns about the vaccines and to help parents navigate the systems to access the vaccines for their children. Local health departments should leverage staff across all programs, not just MCH, ID and school-based health to share information (e.g., environmental health inspectors, violence prevention outreach workers, etc.)*

- *Ensure that community based organizations, community health worker and promotora networks are adequately resourced and equipped with culturally appropriate and scientifically accurate information to do outreach to children, families, and communities, especially those who have experienced a disproportionate burden of COVID illness and other impacts, before and during the vaccine rollout*

- Consider funding and hosting regional tele-townhalls (telephone based outreach that was shown to be an effective in bolstering census turnout within Black, Latinx, and rural communities in the south), to provide caregivers who lack access to regular providers an opportunity to have their questions answered by Black and Latinx clinicians and health care workers.
- Build on already existing and known national communications efforts, particularly those created by and for communities of color (e.g. "The Conversation") and local campaigns, especially bright spots where local leaders, Promotoras and community health workers were able to increase vaccination rates. These campaigns can provide free toolkits for use by medical homes, health departments, and schools, in sharing credible information about the vaccine with their populations.
- Build on learning, infrastructure, best practices and research from adult COVID vaccinations and routine childhood immunizations where public health, health care, community based organizations and community based workforce worked in concert to educate, combat misinformation and increase vaccination rates (utilizing strategies that include community health ambassadors at the hyper-local neighborhood level to do targeted door-knocking, sharing information and answering questions for their neighborhood).

- The federal government should continue to encourage major social network organizations to screen out false anti-vaccine messages, limit the proliferation of hate speech (including anti-vax disinformation) as they do for sexually explicit, violent and threatening messages. They can demonstrate the following along with active surveillance:
  - Develop principles that distinguish "levels of evidence" in the vaccine information they provide so that they can improve identification of disproven/inaccurate, false claims about vaccine safety for their users that have led to the return of childhood diseases, just as they do for sexually explicit, violent and threatening messages.
  - Include information from robust scientific sources, particularly as unscientific misinformation puts vulnerable babies, cancer patients of all ages and immuno-compromised individuals at unnecessary and avoidable risk of serious complications, long term disability and potentially death.
  - Social media companies could go further, exercising corporate responsibility by disseminating science-based health information proactively as "public service announcements" to advance societal well-being and vaccine literacy.
  - Using sources like the **WHO's Vaccine Safety Net** as a basic guide for those organizations, may prove helpful, as they're pre-vetted.
- Avoid shaming people. It is not effective.
- Overwhelming people with overly-technical information and medical jargon is also not effective. Useful messengers (often local and community-based) will be able to translate vaccine science for various health literacy levels.
- Even vaccinated parents are showing trepidation for their children. Given the perception that COVID is less serious in children, some parents may not feel the urgency to have their children vaccinated. We need to be prepared with supportive, factual information that answers their specific questions about the vaccine.
- Positive reinforcement ("Well done, you've just contributed to ending the pandemic!") by provider to parent and child should be given after the shot.

E. CHILD WELL-BEING POLICY

Reimburse and incentivize vaccine counseling: Families will likely have questions for their pediatrician/ primary care regarding vaccines even when it is not a vaccination site. There is no current mechanism to pay for this counseling in current billing and coding systems. In addition, some families will require several rounds of counseling before they are ready to receive a vaccine even from their primary care provider, but the primary care provider can only receive payment when the actual administration happens. Payment systems must encourage appropriate vaccine counseling. This is an urgent problem for CMS, state Medicaid programs, and private insurance to address. A couple of places have added reimbursement for counseling, including North Carolina Medicaid and New York City.

- As COVID-19 vaccines are fully licensed for all school age children, CDC should consider recommending their inclusion along with all the other routine vaccines required for school attendance.
  - We need to strengthen the base of routine child vaccination ASAP, and consider adding the new COVID-19 shot to the list when it becomes available
  - School age required vaccination for everyone is not the only public health tool. If one seeks an exemption from vaccination requirements that puts others at risk, we can provide access to counseling or health information. States that have a more strict exemption process for parental exemptions achieve significantly higher rates of childhood vaccinations. The federal government should develop incentives for vaccination at the community and state level. Medicaid, Medicare and other public-health funding should be increased for states attaining full childhood, timely and equitable COVID vaccine uptake.
  - Provide incentives to families from low income communities to get children vaccinated.

F. FUNDING NEEDS AND INVESTMENTS

- *Provide explicit, permissive guidance to states and locals on how to flexibly use funding from CARES, ARPA, and regular appropriations to maximize equity in vaccine distribution, allocation, communication, and administration for pediatric populations. This may include highlighting administrative barriers that can be waived or deferred.*
- Identify and secure the infrastructure needs to support the vaccination rollout for this population. This could include funding, workforce capacity, and the utilization of IIS.
- The CDC should be funding and offering technical guidance to states, localities, schools and businesses for the development of reliable and secure “proof of vaccination” systems.
- Private and public funding are critical for community based organizations and workforce. If intermediaries are used for this funding, they need understand how to work with and release funds to CBOs.
- Philanthropic partners have an interest in understanding of how private investments can catalyze and leverage federal resources to enable more equitable access and information

- Current child-specific vaccine-related commitments include support for this Kids Vaccinations multi-partner working group and select outreach efforts by the American Academy of Pediatrics by the David and Lucile Packard Foundation.
- Broader population vaccine equity commitments include significant funding and resource provision for local and national COVID response and vaccine equity investments made by The Rockefeller Foundation, The Kresge Foundation, The W.K Kellogg Foundation and the CDC Foundation.

G. OTHER RESOURCES:

- Racial Disparities in COVID-19 Impacts and Vaccinations for Children – KFF
- COVID-19 Resources – School-Based Health Alliance
- Global Immunization Vision and Strategy (GIVS) Guiding Principles and Strategy
- From the Field: Improving Immunization Coverage and Services at the Local Level This document is a collection of local health department stories and highlights a local immunization challenge and initiative to increase vaccine coverage rates. Several of the stories include school-based clinics or partnerships.
- Carrying Equity in COVID-19 Vaccination Forward: Guidance Informed by Communities of Color – CommuniVax Report
- Prioritizing Equitable Access to COVID-19 Vaccines for Children: A Guide for State Advocates -- Families USA

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